Texas Reportable Preventable Adverse Events Definitions and Guidance v1.0 (01/01/2015)

Texas Note **Texas Department of State Health Services**	**The following document includes definitions, specifications and guidance as provided by the National Quality Forum (NQF), Appendix A and B; the Agency for Healthcare Research and Quality (AHRQ) Common Formats Users Guide; the AHRQ Common Format Forms; and the diagnosis codes that have been identified on the FY 2013 Final Healthcare Acquired Condition (HAC) List by CMS.** **Texas DSHS Preventable Adverse Event program agrees with the following definitions and explanations unless otherwise noted in a Texas Note. In addition, other clarifying comments will be included in a Texas Note if indicated.**

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PREVENTABLE ADVERSE EVENT REPORTING EFFECTIVE JANUARY 1, 2015.	Definitions of key terms are included in the Glossary (Appendix B) and, where the terms are used in the event description or additional specifications are considered part of the specifications of the events. Implementation Guidance is not proposed for endorsement. It amplifies statements in the Event and Additional Specifications, which are proposed for endorsement, with examples and explanations based on experience of those organizations / entities that have implemented event reporting as well as recommendations of the NQF Serious Reportable Events Steering Committee. It does not purport to be either comprehensive or even across the events and is not a requirement of either.	The following terms are defined as they apply to the NQF list of serious reportable events. To the extent practicable, they have been harmonized with definitions used in other NQF safety-related products, the Agency for Healthcare Research and Quality's Common Formats, and the World Health Organization's evolving International Classification for Patient Safety. The Common Formats are a product of the requirements of the Patient Safety and Quality Improvement Act of 2005 that provides a structure for reporting adverse events, while the latter provides structure for classifying such events.		
(1a)**Surgery or invasive procedure involving wrong procedure.** **This event must be reported**	WRONG PROCEDURE: Additional Specifications: Defined as any surgery or other invasive procedure performed on a body part or site that is not consistent with the correctly documented informed consent for that patient.	*Informed Consent* involves a process of shared decision making in which discussion between a person who would receive a treatment, including surgery or invasive procedure, and the caregiver/professional person who explains the treatment, provides information about possible benefits,		

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regardless of level of harm assessed.	Surgery or other invasive procedure includes, but is not limited to, endoscopies, lens implants, lesion removal, injection into joints. Excludes emergent situations that occur in the course of surgery or other invasive procedures and/or whose exigency precludes obtaining informed consent. <u>Implementation Guidance:</u> It should be noted that a correctly documented informed consent for patients whose procedures will not be carried out in an operating room may not involve a "surgical consent form"; however, it does require informed consent be documented in the patient record. This event is intended to capture: • insertion of the wrong medical implant into the correct surgical site. This event is <u>not</u> intended to capture: • changes in plan upon entry into the patient with discovery of pathology in close proximity to the intended place where risk of a second surgery/ procedure outweighs benefit of patient consultation, or unusual physical configuration (for example	risks and alternatives, and answers questions that result in the person's authorization or agreement to undergo a specific medical intervention. Documentation of this discussion should result in an accurate and meaningful entry in the patient record, which could include a signed "consent form". Signing a consent form does not constitute informed consent; it provides a record of the discussion. *Surgery* is an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or the procedure is carried out using an instrument that is introduced through a natural body orifice. It includes minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. *Surgeries* include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to vaginal birth or Caesarian delivery to extensive multi-organ transplantation. It does not include use of such things as otoscopes and drawing blood. *Organizations may choose to adopt a list of surgical procedures to supplement*		

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	adhesions, spine level/extra vertebrae)	*the definition above; one example of such a list in common use is that of the Institute of Clinical Systems Improvement.*		
(1b) **Surgery or invasive procedure involving a surgery on the wrong site. This event must be reported regardless of level of harm assessed.**	Additional Specifications: Defined as any surgery or other invasive procedure performed on a body part or site that is not consistent with the correctly documented informed consent for that patient. Surgery or other invasive procedure includes, but is not limited to, endoscopies, lens implants, lesion removal, injection into joints. Excludes emergent situations that occur in the course of surgery or other invasive procedure and/or whose exigency precludes obtaining informed consent. Implementation Guidance: It should be noted that a correctly documented informed consent for patients whose procedures will not be carried out in an operating room may not involve a "surgical consent form"; however, it does require informed consent be documented in the patient record. Although an incorrectly placed surgical mark could result in surgery being			

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	performed on the wrong body part, surgery does not begin at time the surgical mark is made on the patient. Placing a marked on the wrong body part or site does not in itself constitute wrong site surgery. Wrong site surgery or invasive procedure, corrected during the procedure, is still a wrong site procedure if the surgery/procedure had begun, based on the definition in glossary. This event in intended to capture instances of: • Surgery or other invasive procedure on the right body part but on the wrong locations/site on the body; e.g., left/right (appendages/organs), wrong digit, level (spine), stent placed in wrong iliac artery, steroid injection into the wrong knee, biopsy of wrong mole, burr hole on wrong side of skull: • Delivery of fluoroscopy or radiotherapy to the wrong region of the body; • Use of incorrectly placed vascular catheters: • Use of incorrectly placed tubes (for example, feeding tubes place in the lung or ventilation tubes passed into the esophagus).			

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	This event is NOT intend to capture: • Changes in plan upon entry into the patient with discovery of pathology in close proximity to the intended place where risk of a second surgery or procedure outweighs benefit of patient consultation, or unusual physical configuration (for example adhesion, spine level/extra vertebrae).			
(1c) Surgery or invasive procedure involving a surgery on the wrong patient. **This event must be reported regardless of level of harm assessed.**	WRONG PATIENT: Additional Specifications: Defined as any surgical or other invasive procedure performed on a patient that is not consistent with the correctly documented informed consent for that patient. Surgery or other invasive procedure includes, but is not limited to, endoscopies, lens implants, lesion removal, injection into joints. Implementation Guidance: It should be noted that a correctly documented informed consent for patients whose procedures will not be carried out in an operating room may not involve a "surgical consent form"; however, it does require informed consent be documented in the patient record.			

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	This event is intended to capture: • surgical procedures (whether or not completed) initiated on one patient intended for a different patient. Use of accepted patient identification procedures is key to avoiding such events.			
(2) Foreign object retained after surgery. **This event must be reported regardless of level of harm assessed.**	RETAINED FOREIGN OBJECT: Additional Specifications: Includes medical or surgical items intentionally placed by provider(s) that are unintentionally left in place. Excludes: a) objects present prior to surgery or other invasive procedure that are intentionally left in place; b) objects intentionally implanted as part of a planned intervention; and c) objects not present prior to surgery/procedure that are intentionally left in when the risk of removal exceeds the risk of retention (such as microneedles, broken screws). Implementation Guidance: This event is intended to capture: • occurrences of unintended retention of objects at any point after the surgery/procedure ends regardless of setting (post	*Unintended retention* of a foreign object refers to a foreign object introduced into the body during a surgical or other invasive procedure, without removal prior to the end of the surgery or procedure, which the surgeon or other practitioner did not intend to leave in the body. *Surgery begins,* regardless of setting, at point of surgical incision, tissue puncture, or insertion of instrument into tissues, cavities, or organs. *Surgery ends* after all incisions or procedural access routes have been closed in their entirety, device(s) such as probes or instruments have been removed, and, if relevant, final surgical counts confirming accuracy of counts and resolving any discrepancies have concluded and the patient has been taken from the operating/procedure room.	Unintentionally retained item: Foreign object introduced into the body during a surgical operation or another invasive procedure, without removal prior to finishing the surgery or procedure. The surgeon or other practitioner did not intend to leave the object in the body.	998.4 (CC) 998.7 (CC)

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	anesthesia recovery unit, surgical suite, emergency department, patient bedside) and regardless of whether the object is to be removed after discovery; • unintentionally retained objects (including such things as wound packing material, sponges, catheter tips, trocars, guide wires) in all applicable settings.			
(3) Post-operative death of an ASA Class 1 Patient.	Additional Specifications: Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. Immediately post-operative means within 24 hours after surgery or other invasive procedure was completed or after administration of anesthesia (if surgery/procedure not completed). Implementation Guidance: This event is intended to capture: • ASA Class I patient death associated with the administration of anesthesia whether or not the planned surgical procedure was carried out.			
(3) Texas Note	This PAE is applicable for any intraoperative or immediately post-operative/post-procedure death of an ASA Class 1 patient.			

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(4) Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person. **This event must be reported regardless of level of harm assessed.**	Implementation Guidance: The terms "authorized" and "decision-making capacity" are defined in the glossary. Release to "other than an authorized person" includes removing the patient/resident without specific notification and approval by staff, even when the person is otherwise authorized. Examples of individuals who do not have decision-making capacity include: newborns, minors, adults with Alzheimer's. Individual healthcare organizations or other relevant jurisdictional authorities may have specific requirements for assessing decision-making Capacity.	*Authorized* means the guardian or other individual(s) having the legally recognized ability to consent on behalf of a minor or incapacitated individual (surrogate), or person designated by the surrogate to release or consent for the patient. *Decision-making capacity* is the ability to understand information relevant to a decision and the ability to appreciate the reasonably foreseeable consequences of a decision (or lack of a decision).		
(5)Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.	Implementation Guidance: This event is intended to capture: • events in which the line is attached to a reservoir distant from the patient care unit or in a tank near the patient such as E-cylinders, anesthesia machines.			

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This event must be reported regardless of level of harm assessed.				
(6) Abduction of a patient of any age. **This event must be reported regardless of level of harm assessed.**	Implementation Guidance: This event is intended to capture: • removal of a patient/resident, who does not have decision-making capacity, without specific notification and approval by staff even when the person is otherwise authorized to be away from the setting. Examples of individuals who do not have decision-making capacity include: newborns, minors, adults with Alzheimer's.	*Abduction* means the taking away of a person by persuasion, by fraud, or by open force or violence. It includes convincing someone, particularly a minor or a woman he/she is better off leaving with the persuader, telling the person he/she is needed, or that the mother or father wants him/her to come with the abductor. (NQF Glossary) *Authorized* means the guardian or other individual having the legally recognized ability to consent on behalf of a minor or incapacitated individual (surrogate), or person designated by the surrogate to release or consent for the patient. (NQF Glossary) *Decision-making capacity* is the ability to understand information relevant to a decision and the ability to appreciate the reasonably foreseeable consequences of a decision (or lack of a decision).		

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(7) Sexual abuse or assault of a patient within or on the grounds of a health care facility. **This event must be reported regardless of level of harm assessed.**	Implementation Guidance: Language and definitions may vary based on state statute; however, the principle and intent remain regardless of language required based on jurisdiction.	*Sexual abuse* is defined as the forcing of unwanted sexual activity by one person on another, as by the use of threats or coercion or sexual activity that is deemed improper or harmful, as between an adult and a minor or with a person of diminished mental capacity.		
(8) Patient death or severe harm of a patient resulting from a physical assault that occurs within or on the grounds of a health care facility.	Implementation Guidance: Language and definitions may vary based on state statute (e.g., many states have existing statutes that use the terms “first degree assault” or “second degree assault” or “battery”).			
(9) Patient death or severe harm associated with a fall in a health care facility	Additional Specifications: Includes but is not limited to fractures, head injuries, and intracranial hemorrhage. Implementation Guidance: Of note, an assessment that identifies patients at “risk” of fall, findings of risk accompanied		For purposes of patient safety, a fall is a sudden, unintended, uncontrolled, downward displacement of a patient's body to the ground or other object (e.g., onto a bed, chair, or bedside mat).	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854

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resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.	by organizationally defined measures to be taken when risk is identified could be useful in both prevention and event analysis.		This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person). (CF—Fall)	925-929 940-949 991-994
(9) Texas Note	This PAE is the combination of NQF's Serious Reportable Event (SRE) for fall and the HAC fall with injury. The fall SRE intends that any patient death or severe harm associated with a fall is reportable. The HAC is not dependent on a level of harm. Texas DSHS reportable events include any patient death or severe harm that is associated with a fall is reportable. The reporting system Texas Health Care Safety Network (TxHSN) provides choices dependent on the type of resultant injury (fracture, dislocation, intracranial, crushing, burn or other) as denoted in the HAC.			
(10) Patient death or severe harm associated with unsafe administration of blood or blood products.	Implementation Guidance: Unsafe administration includes, but is not limited to, hemolytic reactions and administering: a) blood or blood products to the wrong patient; b) the wrong type; or c) blood or blood products that have been improperly stored or handled. This event is not intended to capture: • patient death or serious injury associated with organ rejection other than those attributable to a hyperacute hemolytic reaction • patient death or injury when cause is not detectable by ABO/HLA matching.		Use this Common Format form to report any patient safety event or unsafe condition involving the processing and/or administration of blood or a blood product. This CF form is not intended for reporting blood or blood product collection and other processes prior to receipt of the product by the blood bank. (CF—Blood/Blood Product)	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)

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(11) Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.	Additional Specifications: Includes events where specimens are misidentified, where another procedure cannot be done to produce a specimen. Includes progression of an undiagnosed disease or threat of disease that changes the patient's risk status for life, requiring monitoring not needed before the event. Implementation Guidance: This event is not intended to capture: • procedures where the specimen was properly handled, but the specimen proved to be nondiagnostic. Inability to secure a replacement for a lost specimen can occur with excisional biopsy as well as in organ removal.			
(12) Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.	Additional Specifications: Includes events where failure to report increased neonatal bilirubin levels result in kernicterus. Implementation Guidance: Examples of serious injury are a new diagnosis, or an advancing stage of an existing diagnosis (e.g., cancer).			
(12) Texas Note	The NQF A Implementation Guidance states that failure to follow up or communicate can be limited to healthcare staff or can involve communication to the patient. Texas DSHS PAE Reporting Program requires that this PAE not be limited and that a failure to follow up or communicate includes failure to communicate to healthcare staff and/or the patient.			

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(13) Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.	Implementation Guidance: The event is intended to capture: • instances where physical restraints are implicated in the death, e.g., lead to strangulation/entrapment, etc.	*Restraints* is defined by The Joint Commission, the Centers for Medicare & Medicaid Services, and by some states. The appropriate source(s) should be consulted for the definition required by the setting and/or jurisdiction in which a presumptive event occurs. In the event none of those definitions apply to an institution, the following definition, which is intended to capture definitions from the named organizations, is offered: *Restraints* means any method of restricting a patient's freedom of movement that is not a usual and customary part of a medical diagnostic or treatment procedure to which the patient or his or her legal representative has consented; is not indicated to treat the patient's medical condition or symptoms; or does not promote the patient's independent functioning.		
(14) Perinatal death or severe harm (maternal or neonatal) associated with labor or delivery in a low-risk pregnancy	MATERNAL: Additional Specifications: Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy. Implementation Guidance: This event is not intended to create a new obligation. The organization's obligation, under this	*Low-risk pregnancy* refers to a woman aged 18-39, with no previous diagnosis of essential hypertension, renal disease, collagen-vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that	Use this Common Format form to report any patient safety event associated with the birthing process or intrauterine procedures that occur during the perinatal period to the mother, fetus(es), or neonate(s). The perinatal period extends from the 20th week of	

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while being cared for in a health care facility.	event, is to report only maternal death or serious injury associated with labor or delivery in a low risk pregnancy when made aware of the maternal death or serious injury either by readmittance or by the patient's family.	poses a high risk of poor pregnancy outcome. *Neonate* is a newborn less than 28 days of age. (NQF Glossary)	gestation through 4 weeks (28 days) postpartum. (CF—Perinatal)	
(14) Texas Note	For Texas DSHS Preventable Adverse Event Reporting: • Maternal death or severe harm that occurs within 42 days postpartum and the death or severe harm is associated with a labor or delivery that occurred in a general hospital, in a low risk pregnancy, is reportable by the facility where the labor and delivery occurred. ✓ For mothers who labored and delivered in a setting other than a general hospital and then transferred into the hospital, Texas PAE reporting does NOT apply. ✓ For mothers who began labor and delivery in another setting but is transferred to a hospital prior to the neonate's birth, PAE reporting would apply if an event occurred. • Neonatal death or severe harm that occurs to a newborn less than 28 days of age and the death or severe harm is associated with a labor or delivery that occurred in a general hospital, in a low risk pregnancy, is reportable by the facility where the labor and delivery occurred. ✓ For neonates that were born in a setting other than a general hospital and transferred into the hospital, Texas PAE reporting does NOT apply. ✓ For neonates whose mother began labor and delivery in another setting and completed labor and delivery in the hospital, PAE reporting would apply if an event occurred. For completion of the Perinatal PAE report: • When reporting a perinatal event that affects the mother, enter the mother's demographics when creating the event. • When reporting a perinatal event that affects the mother and neonate, enter the mother's demographics when creating the event. • When reporting a perinatal event that affects the neonate, enter the neonate's demographics when creating the event. • If a single event affects more than one neonate, enter the demographics for the most severely affected neonate and note injury to other neonate(s) in the narrative. For Texas DSHS Preventable Adverse Event Reporting, events involving a fetus(es) are not reportable.			

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ADDITIONAL DEFINITIONS				
Associated with		*Associated with* means that it is reasonable to initially assume that the adverse event was due to the referenced course of care; further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship.		
Contributing factor			A circumstance determined retrospectively to have increased the likelihood of the event and that is generally external to the patient. They frequently relate to the physical environment or to the care delivery. (AHRQ App 2)	
Devices	Includes, but is not limited to, catheters, drains, and other specialized tubers, infusion pumps, ventilators, and procedural and monitoring equipment. This event is intended to capture: • Occurrences whether or not the use is intended or described by the device manufactures' literature.	*Medical device* is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory, which is recognized in the official national formulary, or the United States Pharmacopoeia, or any supplement to them; intended for use in the diagnosis	Medical device: a medical device is an instrument, apparatus, implement, machine implant, in vitro reagent, or other similar or related article, including a component part, or accessory, intended for use in the diagnosis of disease or	

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		of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.	other conditions, or in the cure, mitigation, treatment, or prevention of disease, or intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of its primary intended purposes (e.g., walker, hearing aid, and medical/surgical supply, including disposable product (e.g., incontinence supply)). (AHRQ App 2)	
Duration of Harm			The period over which disease, disability, disfigurement, dysfunction, etc. may be evident; often denoted as none, transient, temporary (short-term), or permanent (life-long). (AHRQ App 2)	

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Handover/ Handoff			The process when one health care professional updates another on the status of one or more patients for the purpose of taking over their care. Typical examples involve a physician who has been on call overnight telling an incoming physician about patients she has admitted so he can continue with their ongoing management, know what immediate issues to watch out for, and so on. Nurses similarly conduct a handover at the end of their shift, updating their colleagues about the status of the patients under their care and tasks that need to be performed. When the outgoing nurses return for their next duty period, they will in turn receive new updates during the change of shift handover. In addition, it is often used to refer to the information transfer that occurs from one clinical setting to another (e.g., from hospital to nursing home). (AHRQ App 2)	

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Healthcare worker			Healthcare worker, including nursing assistant, patient transport/retrieval personnel, assistant/orderly, clerical/administrative personnel, interpreter/translator, technical/laboratory personnel, pastoral care personnel, biomedical engineer, housekeeping, maintenance, patient care assistant, or administrator/manager. (AHRQ App 2)	
HIT device			An HIT device includes hardware or software that is used to electronically create maintain, analyze, store, or receive information to aid in the diagnosis, cure, mitigation, treatment, or prevention of disease and that is not an integral part of (1) an implantable device or (2) an time of medical equipment. (CF – Device or Medical/Surgical Supply, Including Health Information Technology)	

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Levels of Harm Related to question "After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?			**Death:** Dead at time of assessment. **Severe harm:** Bodily or psychological injury (including pain or disfigurement) that interferes significantly with functional ability or quality of life. **Moderate harm:** Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm. **Mild harm:** Bodily or psychological injury resulting in minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay. **No harm:** Event reached patient, but no harm was evident. (CF--PIF)	
Patient		*Patient* means a person who is a recipient of healthcare. *A person becomes a patient at the point that they are being "cared for" in the facility. Being "cared for" begins when they are first engaged by a member of the care team, e.g. assessment by the triage nurse in the E.D., walking with the*		

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		phlebotomist to the lab for a lab draw. A patient is no longer considered a patient at the point that they are no longer under the care of a member of the care team, e.g. the nursing assistant has safely assisted the patient to the car from an inpatient stay; the ambulating patient that does not need assistance leaves the radiology department following an outpatient test.		
Principal diagnosis			The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. (AHRQ App 2)	
Principal procedure			The procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication. (AHRQ App 2)	
Psychological injury			Harm or damage to a person's psyche, psychological functioning, or mental well-being. (AHRQ App 2)	

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Reporter			Person in a health care organization who reports a patient safety concern; may (or may not) be the person who discovered the concern. (AHRQ App 2)	
Rescue Action			Action taken or started within the first 24 hours after the discovery of a patient safety incident that is intended to prevent, to minimize, or to reverse harm to the affected patient. (AHRQ App 2)	
Texas Note regarding Severe Harm / Serious Injury	NQFs Serious Reportable Events use the phrase "serious injury". AHRQ's Common formats use the term "severe harm" for assessing the level of harm for adverse events. The Texas DSHS Preventable Adverse Event Reporting program elected to be consistent with AHRQ since the reporting model uses AHRQ's Common Formats. Therefore the Texas Administrative Code, Chapter 200.7, uses the term "severe harm" in the list of PAEs. In an attempt to reconcile this difference, the Texas DSHS agrees with these definitions from both NQF and AHRQ and finds that severe harm and serious injury are similar enough to be considered synonymous for reporting purposes.			
Injury		*Injury,* as used in this report has a broad meaning. It includes physical or mental damage that substantially limits one or more of the major life activities of an individual in the short term, which may	Bodily Injury: Physical harm or damage to a person's body. (AHRQ App 2)	

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		become a disability if extended long term. Further, injury includes a substantial change in the patient's long-term risk status such that care or monitoring, based on accepted national standards, is required that was not required before the event. *(Of note, states and other entities may use alternate definitions for the term "disability.")*	Psychological injury: Harm or damage to a person's psyche, psychological functioning, or mental well-being. (AHRQ App 2)	
Harm			Harm: Physical or psychological injury (including increased anxiety), inconvenience (such as prolonged treatment), monetary loss, and/or social impact, etc. suffered by a person, (AHRQ App 2)	
Serious		*Serious* describes an event that can result in death, loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g., higher level of care, surgery).	Severe harm: Bodily or psychological injury (including pain or disfigurement) that interferes significantly with functional ability or quality of life. (CF-PIF)	

References

1. National Quality Forum (NQF), *Serious Reportable Events In Healthcare—2011 Update: A Consensus Report, Appendix A,* Washington, DC: NQF; 2011. Copyright © 2014 National Quality Forum.
http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

2. National Quality Forum (NQF), *Serious Reportable Events In Healthcare—2011 Update: A Consensus Report, Appendix B Glossary,* Washington, DC: NQF; 2011. Copyright © 2014 National Quality Forum.
http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

3. Agency for Healthcare Research and Quality (AHRQ), *Common Formats,* Washington, DC: NQF; 2012.
https://www.psoppc.org/web/patientsafety/commonformats;jsessionid=014472943faece2104a6af29595c

4. Agency for Healthcare Research and Quality (AHRQ), *AHRQ Common Formats Version 1.2,User's Guide, Appendix 2 Glossary,* Washington, DC: NQF; 2012. **https://www.psoppc.org/c/document_library/get_file?uuid=b8ce4ed7-aabd-49a7-b883-fd8a673ad7a5&groupId=10218**

5. Centers for Medicare & Medicaid Services, *FY 2013 Final HACs code list*. Baltimore: Centers for Medicare & Medicaid Services, 2013.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf